STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155106	A. BUILDING	00	07/27/2012
		133100	B. WING	T ADDRESS OWN STATE THE CODE	0112112012
NAME OF I	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE VESTFIELD RD	
RIVERW	ALK VILLAGE			LESVILLE, IN 46060	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F0000	REGULATORY OF	R LSC IDENTIFFING INFORMATION)	TAG	Dia relative 17	DATE
1 0000					
	This visit was fo	or a Recertification and	F0000	The creation and submission	of
	State Licensure	survey. This visit		this Plan of Correction does	
		restigation of Complaints		constitute an admission by temperature of any conclusion seems.	
	IN00110360 and	•		forth in the statement of	51
				deficiencies, or of any violation	on of
	Complaint IN00	0110360: Unsubstantiated		regulation. This Provider	
	due to lack of evidence.			respectfully requests that the 2567 plan of correction be	
				considered the letter of credi	ble
	Complaint IN00	0111398: Unsubstantiated		allegation and requests a de-	
	due to lack of ev	vidence.		review for paper compliance lieu of post survey visit on or	
				August 26, 2012	alter
	1 -	uly 23, 24, 25, 26, and 27,			
	2012				
	D 11.	000044			
	Facility number				
	Provider numbe				
	AIM number: 1	.00274940			
	Survey team:				
	1 -	L.NTeam Coordinator			
	1	N. (7/23, 24, 25, 26)			
	Melanie Strycke				
		,			
	Census bed type				
	SNF/NF145				
	Total145				
	Census payor ty	rpe:			
	Medicare15				
	Medicaid100				
	Other30				
	Total145				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION NUMBER: 155106	(X2) MULTIPLE CO A. BUILDING B. WING	00	СОМР 07/27	LETED 1/2012
	ROVIDER OR SUPPLIER ALK VILLAGE	295 WE	ADDRESS, CITY, STATE, ZIP ESTFIELD RD ESVILLE, IN 46060	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Sample: 24				
	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.				
	Quality review completed 8/2/12 Cathy Emswiller RN				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155106	B. WING		07/27/2012
	PROVIDER OR SUPPLIER		295 WE	ADDRESS, CITY, STATE, ZIP CODE ESTFIELD RD ESVILLE, IN 46060	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F0157 SS=D	A facility must in resident; consult and if known, no representative or member when the resident which the potential for intervention; a si resident's physic status (i.e., a defor psychosocial threatening concomplications); a significantly (i.e., existing form of the consequences, of treatment); or discharge the respecified in §483. The facility must resident and, if knepresentative or when there is a change in resident and assignment as so a change in resident and the facility must resident and the resident a	NE/ROOM, ETC) Inmediately inform the swith the resident's physician; tiffy the resident's legal or an interested family here is an accident involving the results in injury and has requiring physician significant change in the stall, mental, or psychosocial terioration in health, mental, status in either life ditions or clinical an need to alter treatment, a need to discontinue an treatment due to adverse or to commence a new form a decision to transfer or sident from the facility as 3.12(a). It also promptly notify the known, the resident's legal or interested family member change in room or roommate pecified in §483.15(e)(2); or dent rights under Federal or ulations as specified in			
	facility failed to alleged sexual at physician. The d	review and interview, the report an allegation of buse to a resident's efficient practice affected eviewed for alleged	F0157	F157 Notification of Changes is the consistent practice of t Provider to report any and al allegations of abuse to the residents physician.1. What corrective action will be	his I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155106	B. WIN			07/27/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				ESTFIELD RD	
DI\/ED\//	ALK VILLAGE				SVILLE, IN 46060	
				NOBLL		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		5.112
	sexual abuse vio	lations in a sample of 24			accomplished for those resider	
	residents reviewe	ed. [Resident #55]			found to have been affected by	/
					the alleged deficient practice?	
	Findings include				Resident #55 physician was notified of this resident's	
	i mamgs merade	•			statements.2. How will this	
	1 0 7/22/12	11.05 A M			Provider identify other resident	rs I
		11:05 A.M., tour of the			being affected by the same	
	l *	ated with the Assistant			alleged deficient practice?All	
	Director of Nurs	ing [ADoN].			residents making any statemer	nt
					of allegation of abuse regardle	
	At that time, Res	ident #55 was identified			of true, false, mental status or	
		ors such as refusal of			diagnosis can be affected by the	ne
	care and medicat				alleged deficient practice.Any	
	care and medical	10113.			residents making such allegati will be investigated per policy v	
	0 7/04/10 . 4	00 P. M. P 1			physician notification.3. What	
		00 P.M., Resident #55's			measures will be put into place	
	record was revie	•			and/or what sytematic changes	
	included, but we	re not limited to,			will be made to ensure that the	
	schizophrenia, de	ementia, depression,			alleged deficient practice does	
	anxiety, and hall	ucinations.			not recur?The charge nurse w	
	3 /				immediately was told by staff of	
	Δ "Rehavior Car	re Plan" dated 5/29/12,			this allegation went to Residen	
	included, but wa	·			#55 and questioned this reside about the allegation. Resident	
	· ·	-			#55 stated that she did make t	
		Date: 5/29/12 Behavior:			allegation however was only	
		usions about others.			kidding to get the staff's	
	Resident believe	s that other people who			attention. The charge nurse w	as
	are not present ca	all her names Goal:			re-educated of facility abuse	
	Resident will have	ve no signs or symptoms			policy by Staff Development	
		alse perceptions			coordinator to properly report a	any
		ate of 5/29/12: Staff will			allegation to the Executive Director and to other officials -	
		offer drink, take			including the resident physicial	n -
		om to eliminate external			in accordance with state law.	
					staff were re-educated	
	· ·	MD when necessary for			8-14-12 on the facility abuse	
		ation, and staff will offer			policy by DNS/Staff Developm	ent
	resident a snack.	"			Coordinator to ensure proper	
					investigation and reporting of a	all

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION (IDENTIFICATION NUMBER: 155106	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2012
	PROVIDER OR SUPPLIER VALK VILLAGE	STREET A	ADDRESS, CITY, STATE, ZIP CODE ESTFIELD RD SVILLE, IN 46060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	A quarterly, "Minimum Data Set" assessment, dated 7/10/12, included, but was not limited to, "Brief Interview Mental Status: 10 [moderate cognitive impairment]" An event, dated 7/21/12 at 5:54 A.M., initiated by Licensed Practical Nurse [LPN]#5, indicated Resident #55 stated a Certified Nursing Assistant [CNA] molested her. The event indicated family was not notified and the immediate intervention implemented was to attend to Resident #55's needs promptly. No documentation was located in the resident's clinical record regarding notification of the resident's physician. On 7/25/12 at 3:30 P.M., the facility investigation of the alleged sexual abuse of Resident #55 was requested from the Administrator and DoN. On 7/26/12 at 9:30 A.M., the facility investigation was provided by the DoN. At that time, in an interview, the DoN, indicated the incident was not reported to ISDH because Resident #55 changed her story regarding the allegation of abuse. Also, the DoN indicated LPN #5 did not notify the Administrator or on-call Nursing Supervisor of the incident.		incidents are followed per policand in accordance with state laws.ED and/or DNS will ensurallegations are properly report to residents physician.4. How the corrective action be monitored to ensure the alleged deficient practice does not recur?To ensure ongoing and consistent compliance, the DNS and/or designee is responible for completion the Change in Condition (physician notification and Abuse CQI audit tool. The audit will occur weekly for 4 weeks, then bi-monthly for 2 months and quarterly until compliance is consistently meand maintained for at least 6 months. The results of these audits will be reviewed by the committee. If the results of 10 is not achieved, the committee will create an action plan to ensure ongoing compliance.	re ed will ored t CQI 0%

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED
		155106	B. WIN	G		07/27/2012
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE	
					STFIELD RD	
RIVERW	ALK VILLAGE			NOBLE:	SVILLE, IN 46060	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1	ocial Service Director				
		e investigation on				
	7/21/12, no time	given.				
	_	n included, but was not				
	limited to:					
		ent from the SSD, dated				
	· · · · · · · · · · · · · · · · · · ·	, included, but was not				
	-	with resident [Resident				
		SS was notified about				
		ion that she told staff that				
		d by a nurse aide. Per				
		ter stated that she just said				
		attention Resident				
		ays things to get people's				
	attention Per re	esident, resident has a				
		tinguishing reality versus				
	delusions per r	resident's sister, she				
	makes things up.	"				
	The resident's sis	ster or legal				
	•	as notified at an unknown				
	date or time per	the above written				
	statement from t	he SSD.				
	A written statem	ent from the DoN, dated				
	7/24/12, no time	, included, but was not				
	limited to, "Follo	ow up to comment made				
	by [Resident #55	5] to 2 CNAs on				
	7/21/12 While	providing care to this				
	resident she mad	le the comment that she				
	had been moleste	ed. The CNAs [not				
		estigation] reported this to				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE (COMPL		
ANDILAN	OF CORRECTION	155106		LDING	00	07/27/	
		155100	B. WIN			011211	2012
NAME OF F	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
RIVERW	ALK VILLAGE				STFIELD RD SVILLE, IN 46060		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	their charge nurs	e [LPN #5] This nurse					
	went immediatel	y to the resident and					
		ad occurred The					
	resident stated th						
	regarding being i	molested wasn't true					
	She just wanted i	up and the CNAs were					
	not moving fast of	enough for her The					
	buddy system is	utilized when providing					
	care to [Resident	#55] as she frequently					
	makes false state	ments Additionally, the					
	video was review	ved and it confirmed that					
	both CNAs went	into [Resident #55's]					
	room to provide	care and that no one					
	other than [LPN	#5] had entered the					
	room Residents	s were interviewed for					
	the purpose of de	etermining similar					
	behavior No ot	her residents expressed					
		regard The Unit					
	_	ewed the staff and					
		ne statement was made to					
	· ·	providing [Resident					
	_	e night of 7/21/12 and					
	•	resent with the resident as					
	required by the re	esident care sheet and the					
	care plan"						
	2 On 7/23/12 at	1:00 P.M., the facility					
		id procedures were					
	_	facility Administrator.					
	provided by the i	acinty Administrator.					
	The abuse policie	es and procedures					
	included, but we	re not limited to,					
	"Resident Abuse	The Executive					
	Director and/or I	Director of Nursing will					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155106	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/27/2012
	ROVIDER OR SUPPLIER ALK VILLAGE	295 WE	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD ESVILLE, IN 46060	Е
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION
	be notified the physician will be notified and orders will be received for treatment and/or discharge based upon assessment"			
	3.1-5(a)(2)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155106	B. WING		07/27/2012
	PROVIDER OR SUPPLIE ALK VILLAGE	R	295 WI	ADDRESS, CITY, STATE, ZIP CODE ESTFIELD RD ESVILLE, IN 46060	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	483.13(c)(1)(ii)-INVESTIGATE/ALLEGATIONS The facility mushave been foun neglecting, or mof law; or have state nurse aideneglect, mistreamisappropriation any knowledge law against and indicate unfitnes or other facility registry or licens The facility mushication involvabuse, including and misappropried immediate facility and twith State law the procedures (incertification ageness) The facility mushalleged violation and must prevewhile the investional must prevewhile the investional maccon (including to the agency) within sand if the allegency appropriate controls.	REPORT //INDIVIDUALS It not employ individuals who diguilty of abusing, histreating residents by a court had a finding entered into the energistry concerning abuse, attend of residents or in of their property; and report it has of actions by a court of employee, which would as for service as a nurse aide staff to the State survey and including to the administrator of oother officials in accordance nrough established luding to the State survey and including to the State survey and including to the State survey and certification is in progress. Il investigations must be administrator or his esentative and to other redance with State law as State survey and certification of working days of the incident, and violation is verified rective action must be taken.			
		review and interview, the report an allegation of	F0225	F225 Investigation / Report / Allegations / Individuals - It is consistent practice of this	08/26/2012 the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155106	B. WIN			07/27/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L			ESTFIELD RD	
חו/רט//						
RIVERV	ALK VILLAGE			NOBLE	SVILLE, IN 46060	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	alleged sexual at	ouse immediately to the			Provider to report any allegation	on
	_	trator, Director of			of abuse immediately to the	
	1 *	e Supervisor, and to			Administrator, Director of nurs	<u> </u>
	_ ·	•			or Nurse supervisor and to sta	te
	_	The deficient practice			agencies.1. What Corrective	
	affected 1 of 1 re	esidents reviewed for			action will be accomplished for	ſ
	alleged sexual at	ouse violations from a			those residents found to have	
	sample of 24 res	idents reviewed.			been affected by the alleged deficient practice?Resident #5	
	[Resident #55]				made an allegation of abuse to	
	[resident #88]				her c.n.a's which in return	´
	Tr. 1 1 1				immediately told their supervis	sor -
	Findings include	:			the charge nurse. The superv	· · · · · · · · · · · · · · · · · · ·
					charge nurse immediately	
	On 7/23/12 at 11	:05 A.M., tour of the			investigated this allegation by	
	facility was initia	ated with the Assistant			interviewing resident #55. The	÷
	Director of Nurs	ing [ADoN]			resident stated that she did ma	ake
					the allegation but that she was	;
	A 4 4 h a 4 4 inn a Daa	.: 4 : 4 : 4 i			only kidding to get the staff	
	· ·	sident #55 was identified			attention and agreed statemer	its
		ors such as refusal of			like this should not be made	
	care and medicat	tions.			unless true. The charge nurse properly ensured resident #55	
					was free from abuse by	
	On 7/24/12 at 4:0	00 P.M., Resident #55's			immediately investigating her	
	record was revie				allegation. Further investigation	n l
	included, but we	•			was completed by the ED, DN	
		•			and social service to validate t	
		ementia, depression,			no abuse occurred and further	•
	anxiety, and hall	ucinations.			validated this was a consistent	t e
					behavior with resident #55	
	A "Behavior Car	re Plan" dated 5/29/12,			making false statements as	
	included, but wa	s not limited to,			indicated in her care plan. The	
		Date: 5/29/12 Behavior:			charge nurse was re-educated	OII
		usions about others.			this Provider abuse policy to properly investigate and report	t to
					the proper officials as required	· · · · · · · · · · · · · · · · · · ·
		s that other people who			policy and in accordinance with	-
	_	all her names Goal:			law. The physician and family	
	Resident will have	ve no signs or symptoms			were also notified to discuss th	
	of delusions or fa	alse perceptions			allegation. If this resident repo	rts
	Approach with d	ate of 5/29/12: Staff will			any further allegations of	
	l **					ı

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		155106	A. BUI. B. WIN			07/27/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ESTFIELD RD		
	ALK VILLAGE				SVILLE, IN 46060		
RIVERVV	ALK VILLAGE			NOBLE	SVILLE, IN 46060		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	approach calmly	, offer drink, take			such, the allegation will be		
	resident to her ro	oom to eliminate external			immediately investigated and		
		MD when necessary for			reported per policy.2. How wil	I	
					this Provider identify other		
		uation, and staff will offer			residents being affected by the		
	resident a snack.	"			same alleged deficient practice All residents making any	e?	
					allegation of abuse could be		
	A quarterly, "Mi	nimum Data Set"			affected by the alleged deficie	nt	
	assessment, date	d 7/10/12, included, but			practice. Any residents that		
	-	to, "Brief Interview			allegegations of abuse will be		
		10 [moderate cognitive			reported to ED and or DNS for	-	
		To [moderate cognitive			proper investigation and repor		
	impairment]"				per policy.3. What measures	will	
					be put into place and/or what		
	An event, dated	7/21/12 at 5:54 A.M.,			systematic changes will be ma	ade	
	initiated by LPN	#5, indicated Resident			to ensure that the alleged		
	#55 stated a C.N	.A. molested her. The			deficient practice does not rec	ur?	
		family was not notified			The charge nurse, who	off	
	and the immedia	-			immediately was told by her st of this allegation, went to resid		
					#55 and inquired about the	iciit	
	-	s to attend to Resident			allegation. Resident #55 state	hd	
	#55's needs pron	nptly.			that she did make the allegation		
					however was only kidding to g		
	A progress notes	s, dated 7/21/12 at 6:02			staff's attention. The charge		
	A M indicated	Resident #55 stated a			nurse was re-educated of the		
	· ·	itified in the abuse			facility abuse policy to properly		
	_				report any and all allegations t	0	
		olested her; however,			the Executive Director and to		
		terviewed the resident,			other officials in acccordance	with	
	Resident #55 inc	licated the allegation was			the state laws.All staff were		
	not true.				re-educated 8-14-12 on the facility abuse policy by Staff		
					Development Coordinator to		
	There was no do	cumentation that the			ensure identification, proper		
		trator, Director of			investigation and reporting of a	all	
	_				incidents are followed per police		
		or nursing supervisor was			and in accordance with state	-	
	immediately not	ified.			laws.Residents who alledge		
					abuse will have a complete		
	On 7/25/12 at 3:	30 P.M., the facility			investigation initiated. Staff wi	ill	

	OF CORRECTION OF CORRECTION 155106 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 07/27/2012
	PROVIDER OR SUPPLIER VALK VILLAGE	295 WE	ADDRESS, CITY, STATE, ZIP CODE ESTFIELD RD SVILLE, IN 46060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	investigation of the alleged sexual abuse of Resident #55 was requested from the Administrator and DoN. At that time, in an interview, the DoN indicated Resident #55 changed her story [regarding being molested] immediately upon LPN #5 interviewing her. In addition, the DoN indicated Resident #55 had a history of making false statements and a history of false perceptions. On 7/26/12 at 9:30 A.M., the facility investigation was provided by the DoN. At that time, in an interview, the DoN, indicated the incident was not reported to ISDH because Resident #55 changed her story regarding the allegation of abuse. Also, the DoN indicated LPN #5 did not notify the Administrator or on-call Nursing Supervisor of the incident. However, the Social Service Director [SSD] started the investigation on 7/21/12, no time given. The investigation included, but was not limited to: A written statement from the SSD, dated 7/21/12, no time, included, but was not limited to, "Met with resident [Resident #55] this date. SS was notified about		report allegations of abuse to their immediate supervisor. ED/DNS will be notified immediately. ED will review e allegation to ensure reporting all appropriate agencies is initated per isdh guidelines an ensure investigation is comple All allegations of abuse, negle and / or misappropration of property will be reviewed by III team to ensure proper investigation and reporting is completed.4. How will the corrective action be monitored ensure the alleged deficient practice does not recur?To ensure ongoing and consistent compliance, the DNS and/or designee is responible for completion the Abuse CQI aud tool. This audit will occur wee for 4 weeks, then bi-monthly for months and quarterly until compliance is consistently me and maintained for 6 months. results of these audits will be reviewed by the CQI committee if the results of 100% is not achieved, the committee will create an action plan to ensur ongoing compliance.	to d to ete. ct DT I to dit kly or 2 t The
	7/21/12, no time, included, but was not limited to, "Met with resident [Resident			

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Event ID: OXCD11

Facility ID: 000044

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PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
		155106		LDING		07/27/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				STFIELD RD		
RIVERW	ALK VILLAGE			NOBLE	SVILLE, IN 46060		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		d by a nurse aide. Per					
	· · · · · · · · · · · · · · · · · · ·	er stated that she just said					
		attention Resident ys things to get people's					
		esident, resident has a					
		tinguishing reality versus					
		esident's sister, she					
makes things up"							
	makes timigs up.	••					
	A written statem	ent from the DoN, dated					
7/24/12, no time, included, but was not							
limited to, "Follow up to comment made							
	by [Resident #55] to 2 C.N.A.s on						
	7/21/12 While	providing care to this					
	resident she mad	e the comment that she					
	had been moleste	ed. The C.N.A.s [not					
	identified in inve	estigation] reported this to					
	their charge nurs	e [LPN #5] This nurse					
		y to the resident and					
		ad occurred The					
	resident stated th						
		molested wasn't true					
	_	up and the C.N.A.s were					
	_	enough for her The					
	1	utilized when providing					
	-	#55] as she frequently					
		ements Additionally, the					
		ved and it confirmed that					
		nt into [Resident #55's]					
	-	care and that no one					
	_	#5] had entered the s were interviewed for					
		etermining similar					
		her residents expressed					
	ochaviol INO Ol	ner residents expressed					

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Event ID: OXCD11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155106		A. BUILDING B. WING	00	COMPLETED 07/27/2012			
	PROVIDER OR SUPPLIER ALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLE	ETION		
	any issues in this regard The Unit Manager interviewed the staff and confirmed that the statement was made to the C.N.A.s while providing [Resident #55's] care on the night of 7/21/12 and that both were present with the resident as required by the resident care sheet and the care plan" The facility failed to immediately report the incident to the facility Administrator, DoN, or Nursing Supervisor, and failed to report to ISDH. 3.1-28(c)						

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Event ID: OXCD11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155106	B. WIN			07/27/	2012
(F. 6F. F				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>			STFIELD RD		
	ALK VILLAGE		NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0226 SS=D	483.13(c) DEVELOP/IMPL ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property. Based on record facility failed to Prohibition Policies to reporting alleg Administrator, Dispervisor, and Sideficient practice reviewed for alleviolations in a said reviewed. [Resident procedure of Nursident Properties of Nu	: 11:05 A.M., tour of the ated with the Assistant ing [ADoN]. iident #55 was identified ors such as refusal of ions. 00 P.M., Resident #55's wed. Diagnoses	F02	26	F226 Development / Implement Abuse / Policies - It is the consistent practice of this Provider to implement and folk Abuse prohibition policies related to reporting to appropriate parties.1. What Corrective act will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #55 made at allegation of abuse to her c.n.c. which in return immediately to their supervisor - the charge nurse. The supervisor charge nurse immediately investigated this allegation by interviewing resident #55. The resident state that she did make the allegation but that she was only kidding the get the staff attention and agrestatements like this should not made unless true. The charge nurse properly ensured resident #55 was free from abuse by immediately investigating her allegation. Further investigation was completed by the ED, DN and social service to validate to no abuse occurred and further validated the consistent.	bow ted ion int in a's did ited ion o eed eent in Sint	08/26/2012
	anxiety, and hall	ucmations.			behavior of Resident #55 mak false statements as indicated i her care plan. The charge nurs	n	

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Event ID: OXCD11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:		00	COMPLETED	
	155106	A. BUILDING		07/27/2012	
		B. WING		0172172012	
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE		
			295 WESTFIELD RD		
RIVERW	RIVERWALK VILLAGE		ESVILLE, IN 46060		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	<u> </u>	5.112	
	A "Behavior Care Plan" dated 5/29/12,		was re-educated on this Prov	ider	
	included, but was not limited to,		abuse policy to properly		
	"Problem Start Date: 5/29/12 Behavior:		investigate and report to the		
	Resident has delusions about others.		proper officials as required by		
			policy and occordane with law The physician and family wer		
	Resident believes that other people who		also notified to discuss the		
	are not present call her names Goal:		allegation.2. How will this		
	Resident will have no signs or symptoms		Provider identify other resider	nts	
	of delusions or false perceptions		being affected by the same		
	Approach with date of 5/29/12: Staff will		alleged deficient practice?All		
	approach calmly, offer drink, take		residents making any allegati	on	
	resident to her room to eliminate external		of abuse could be affected by		
			alleged deficient practice.Any		
	stimulus, refer to MD when necessary for		residents that allegegations	_	
	medication evaluation, and staff will offer		of abuse will be reported to E and or DNS for proper	D	
	resident a snack"		_		
			investigation and reporting perpolicy.3. What measures will		
	A quarterly, "Minimum Data Set"		put into place and/or what	De	
	assessment, dated 7/10/12, included, but		systematic changes will be m	ade	
			to ensure that the alleged		
	was not limited to, "Brief Interview		deficient practice does not re-	cur?	
	Mental Status: 10 [moderate cognitive		The charge nurse, who		
	impairment]"		immediately was told by her s	taff	
			of this allegation, went to resi	dent	
	An event, dated 7/21/12 at 5:54 A.M.,		#55 and inquired about the		
	initiated by LPN #5, indicated Resident		allegation. Resident #55 stat		
	#55 stated a CNA molested her. The		that she did make the allegat		
			however was only kidding to	get	
	event indicated family was not notified		staff's attention. The charge nurse was re-educated of the		
	and the immediate intervention		facility abuse policy to proper		
	implemented was to attend to Resident		report any and all allegations	,	
	#55's needs promptly.		the Executive Director and to		
			other officials in accordance	with	
	A progress notes, dated 7/21/12 at 6:02		the state laws.All staff were		
	A.M., indicated Resident #55 stated a		re-educated on the facility ab		
			policy to ensure identification		
	CNA [not identified in the abuse		proper investigation and repo		
	investigation] molested her; however,		of all incidents are followed p		
	when LPN #5 interviewed the resident,		policy and in accordance with		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155106	B. WIN			07/27/2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		295 WE	STFIELD RD		
	ALK VILLAGE			NOBLE	SVILLE, IN 46060		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL					
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE	
	Resident #55 indicated the allegation was				state laws. Residents who alle abuse will have a complete	age	
	not true.				investigation initiated. Staff wi	ıı İ	
					report allegations of abuse to		
	There was no do	cumentation that the			their immediate supervisor.		
	facility Administ	trator, Director of			ED/DNS will be notified		
	Nursing [DoN],	or nursing supervisor was			immediatlely. ED will review e		
	immediately noti	ified.			allegation to ensure reporting t all appropriate agencies is	.0	
	_				initated per isdh guidelines and	d to	
	On 7/25/12 at 3:3	30 P.M., the facility	· · · · · · · · · · · · · · · · · · ·				
	investigation of the alleged sexual abuse				All allegations of abuse, negle	ct	
of Resident #55 was requested from the					and / or misappropration of		
	Administrator and DoN.				property will be reviewed by ID team to ensure proper)	
	rammistrator an	a Dorv.			investigation and reporting is		
	At that time in a	n interview, the DoN			completed.4. How will the		
					corrective action be monitored	to	
		nt #55 changed her story			ensure the alleged deficient		
		molested] immediately			practice does not recur?To		
		erviewing her. In			ensure ongoing and consisten compliance, the DNS and/or		
	· · · · · · · · · · · · · · · · · · ·	N indicated Resident #55			designee is responible for		
	_	making false statements			completion the Abuse CQI aud	lit	
	and a history of f	false perceptions.			tool. This audit will occur weel		
					for 4 weeks, then bi-monthly for	or 2	
		30 A.M., the facility			months and quarterly until compliance is consistently met		
	investigation was	s provided by the DoN.			and maintained for 6 months.		
	At that time in a	n interview the DeM			The results of these audits wil reviewed by the CQI committe		
		in interview, the DoN,			If the results of 100% is not	с .	
		ident was not reported to			achieved, the committee will		
		esident #55 changed her			create an action plan to ensure	e	
	, , ,	he allegation of abuse.			ongoing compliance.		
	· ·	ndicated LPN #5 did not					
	1	nistrator or on-call					
		sor of the incident.					
	However, the Social Service Director [SSD] started the investigation on						
	7/21/12, no time	given.					

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Event ID: OXCD11

Facility ID: 000044

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155106	B. WING		07/27/2012		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
RIVERW	ALK VILLAGE		295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	I	(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	The investigation included, but was not limited to:						
	7/21/12, no time, limited to, "Met #55] this date. S resident's allegat she was molested staff, resident lat that to get staff's confirmed she sa attention Per redifficult time dis delusions per redifficults	ent from the SSD, dated included, but was not with resident [Resident S was notified about ion that she told staff that d by a nurse aide. Per er stated that she just said attention Resident ys things to get people's esident, resident has a tinguishing reality versus esident's sister, she "					
	makes things up" A written statement from the DoN, dated 7/24/12, no time, included, but was not limited to, "Follow up to comment made by [Resident #55] to 2 CNAs on 7/21/12 While providing care to this resident she made the comment that she had been molested. The CNAs [not identified in investigation] reported this to their charge nurse [LPN #5] This nurse went immediately to the resident and asked her what had occurred The resident stated that her statement regarding being molested wasn't true She just wanted up and the CNAs were not moving fast enough for her The buddy system is utilized when providing						

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PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155106		A. BUILDING B. WING			COMPLETED 07/27/2012			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER			295 WESTFIELD RD				
RIVERWALK VILLAGE					SVILLE, IN 46060			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE	
1710		#55] as she frequently		1710	<u> </u>		DATE	
	=	ments Additionally, the						
		yed and it confirmed that						
		into [Resident #55's]						
		care and that no one						
	•	#5] had entered the						
	_	s were interviewed for						
		etermining similar						
		her residents expressed						
		regard The Unit						
	Manager interviewed the staff and							
confirmed that the statement was made to								
	the CNAs while	providing [Resident						
		e night of 7/21/12 and						
	_	esent with the resident as						
	_	esident care sheet and the						
	care plan"							
	-							
	The facility failed	d to immediately report						
	the incident to the	e facility Administrator,						
	DoN, or Nursing	Supervisor, and failed to						
	report to ISDH.							
		1:00 P.M., the facility						
	•	d procedures were						
	provided by the f	facility Administrator.						
	_	es and procedures						
	· ·	re not limited to, "Sexual						
		, but is not limited to,						
		nt, sexual coercion, or						
	sexual assault A							
		must be reported to the						
	Executive Direct	or immediately, and to						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155106	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/27/2012			
	PROVIDER OR SUPPLIER ALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION			
	the resident's representative within 24 hours of the report Failure to report will result in disciplinary action, up to and including immediate termination The Executive Director/designee will report all unusual occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health" 3.1-28(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLET			ETED	
		155106	B. WIN			07/27/	2012
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
RIVERW.	ALK VILLAGE		295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0314	483.25(c)	(00 TO DDE) (ENT/LIE)					
SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES						
		mprehensive assessment of					
		icility must ensure that a					
		ers the facility without					
		loes not develop pressure					
	sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and						
		es from developing.	F0314				
	•	• •			F314 Treatment / Prevent / He	val	08/26/2012
	Based on observation, interview, and		103	17	Pressure sores - It is the	ai	06/20/2012
		e facility failed to ensure			consistent practice of this		
	the brief of Resid	dent #72 was removed in			Provider to ensure residents w	/ho	
	a way that reduce	ed the potential for skin			have pressure sores receives		
	damage caused b	y shearing or friction.			necessary treatment and servi	ces	
	This deficient pra	actice affected 1 of 6			to promote healing and		
	residents reviewe	ed who had pressure			prevention of new sores developing.1. What Corrective	_	
	sores, in a sample	•			action will be accomplished for		
	seres, in a samp	• • • • • • • • • • • • • • • • • • •			those residents found to have		
	Findings include				been affected by the alleged		
	rindings include	•			deficient practice?This event v	vith	
					the state surveyor occured on		
	In an interview d	•			7-25-12. Resident #72 skin wa		
		on 7/23/12, at 10:50			assessed to ensure no negative	⁄e	
	A.M., L.P.N. #4	indicated Resident #72			outcome occurred with this alleged practice. On 7-27-12,		
	had a pressure so	ore on her coccyx and that			Resident #72 area was assess	sed	
	Resident #72 had	d acquired the pressure			and identified as completely		
	sore while residing	ng at the facility.			healed with no skin issues rela	ited	
		- •			to this alleged finding.2. How	will	
	On 7/23/12, at 2:	20 P.M., the clinical			this Provider identify other		
		ent #72 was reviewed.			residents being affected by the		
					same alleged deficient practice All residents with wounds have		
	_	led, but were not limited			the potential to be affected by		
		anxiety, dementia,			alleged practice. Nursing staff		
	chronic obstructi	ve pulmonary disease,			were re-educated on the		
			1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155106	B. WIN			07/27/2	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ESTFIELD RD		
RIVERW	RIVERWALK VILLAGE				SVILLE, IN 46060		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE
	esophageal reflux, Alzheimer's dementia, chronic kidney disease, and heart failure.				incontinent care, brief applicat and removal by the Staff	ion	
					Development coordinator		
					8-14-12.3. What measures w	ill	
	An Event Note	dated 7/20/12, indicated			be put into place and/or what		
	that Resident #7	2 had an "existing" area			systematic changes will be ma	ade	
	measuring 0.5 c	m x 0.1 cm x 0.1 cm to			to ensure that the alleged		
	her coccyx and that the open area was a				deficient practice does not rec LPN #4 was provided	:ur?	
	stage III.	1			re-education by the Staff		
	On 7/25/12, at 10:25 A.M., a dressing change was observed for Resident #72.				Development Coordinator rela	ited	
					to the proper removal of briefs		
					from a resident with return		
	L.P.N. #3 was observed to remove the				demonstration.Nursing staff w		
					re-educated on the incontinen	t	
		by pulling the brief out			care, brief application and removal by the Staff Developr	nent	
		resident, pulling on the			coordinator 8-14-12.Nursing s		
	1	g friction. A dressing was			were provided with a skills che		
	observed over the	ne coccyx area. L.P.N. #3			off related to brief application		
	was observed to	remove the dressing.			removal.4. How will the		
	Under the dressi	ing a small open area was			corrective action be monitored	l to	
	observed to be c	covered with ointment.			ensure the alleged deficient practice does not recur?To		
	The wound area	was pink in color.			ensure ongoing and consisten	ıt İ	
		•			compliance, the DNS and/or	-	
	On 7/27/12, at 1	0:40 A.M., L.P.N. #4			designee is responible for		
	· ·	y titled, "Incontinent			completion of the Pressure		
		ion." This policy			Wounds - Treatment CQI auditool. This audit will occur wee		
		as not limited to, the			for 4 weeks, then bi-monthly for	•	
		fasten and remove brief			months and quarterly until	J	
	resident is curre				compliance is consistently me	t	
	resident is cuffe	my wearing.			and maintained for 6 months.		
		·			The results of these audits wi		
	_	view at this same time,			reviewed by the CQI committed If the results of 95% is not	e.	
	L.P.N. #4 indicated the normal practice				achieved, the committee will		
	_	orief is to roll the brief			create an action plan to ensur	e	
		side in; continue to roll the			ongoing compliance.		
	brief, pushing th	ne brief under the resident;					
	roll the resident	over the brief, and					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155106		A. BUILDING B. WING	00	COMI	PLETED 7/2012			
	PROVIDER OR SUPPLIER	.	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
PREFIX	(EACH DEFICIEN REGULATORY OR	CY MUST BE PERCEDED BY FULL		(EACH CORRECTIVE ACTION SE	HOULD BE	COMPLETION		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OXCD11

Facility ID: 000044

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	а віл	LDING	00	COMPLETED	
		155106	B. WIN			07/27/	2012
NAME OF F	AD CHARLED OR CHARLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		295 WE	STFIELD RD		
	ALK VILLAGE			NOBLE	SVILLE, IN 46060		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG F0371 SS=F	483.35(i) FOOD PROCUR STORE/PREPAI The facility must (1) Procure food considered satist local authorities; (2) Store, prepar under sanitary of Based on observer record review, th properly store an kitchen, and 1 of deficient practice affect 142 of 145 food prepared in addition, the facil sanitary storage for cans of supplement resident's floor. affected 1 of 1 re supplement use it residents reviewed. Findings include	RE, RE/SERVE - SANITARY - from sources approved or factory by Federal, State or and fe, distribute and serve food conditions ation, interview, and fe facility failed to de handle food in 1 of 1 for dining rooms. This fe had the potential to for residents who consume the facility kitchen. In flity failed to provide for a resident's individual for a resident's individual for the facility has been as the facility and the form of the for a resident form of the form a sample of 24 fed. [Resident #47]	F03	TAG		nts y A. ed r to oble y n	DATE 08/26/2012
		of the kitchen was			cups were properly covered ar	nd	
	*				dated prior to serving.I. The		
	initiated with the	Dietary Manager [DM].			bananas were discarded and rused in serving.J. 2 boxes of	not	
	During that time.	, the following was			noodles were stored in sanitar		
	observed in the v	valk-in refrigerator:			conditions; however they were moved lower so they would no within 12 inches from the		
	A. 11 trays filled	d with small bowls of			ceiling.K. the Tray of cookies	and	
	_	tray with bowls of ready			pies were properly covered an	d	
	-	, ,			dated for proper service for		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155106	B. WIN		-	07/27/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ESTFIELD RD		
RIVERW	ALK VILLAGE				SVILLE, IN 46060		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to serve salad. 7	The 12 trays were open to			residents.(3) resident #47		
	air and 4 of 12 trays lacked a use by date or preparation date. B. One large clear container of pineapple supplement cans were not individually on the floor. The cans were in a cardboard case preventing any cans from touching the floor. The case was						
						ans	
					touching the floor. The case v	/as	
	_				moved from the floor to a sheli		
	without a use by	date or preparation date.			Dietary aide #1 was removed	(-)	
					from the schedule until her hai	nd	
	-	ge cheese [5 pound			properly healed and could wor		
	use by date. D. 2 large metal containers and 1 smaller staff we that proof hair. served				without an ace wrap. All dieta		
					staff were provided with hairne		
			that properly covered entire he of hair.(8)the pitchers made ar				
					served daily per residents requ		
					was labeled and properly	2001	
	identification or	• •			served.2. How will this Provide	er	
		-			identify other residents being		
		. [The DM indicated 2			affected by the same alleged		
		and 1 mashed potatoes			deficient practice?All residents		
	prepared that day	y for lunch service].			utilizing food and drink service		
					from this Providers kitchen have the potential to be affected by		
	E. 1 gallon each	of 3 different liquids			alleged deficient practice. Diet		
	open to air with	out identification, and not			staff were re-educated by the	ui y	
	dated with use b	y or preparation date.			Registered Dietician regarding		
		ted the liquids were			proper hand washing, proper i		
	apple, prune, and	_			of hair nets, food storage, food	I	
	appie, prune, and	a orange juicej.			dating and food service under		
	F 1 -1				proper sanitary conditions3.		
		iner of apple sauce			What measures will be put into place and/or what systematic)	
		d lid and without a use by			changes will be made to ensur	·e	
	or preparation da	ate.			that the alleged deficient pract		
					does not recur?Items identified		
	G. 1 tray of 30 s	small cups of liquid			were properly corrected with		
	without identific	ation or use by or			dates, covers and properly sto		
	preparation date	. [The DM identified as			and served in sanitary condition		
	* *	er and nectar thick			Dietary staff were re-educated	υy	
	cranberry juice].				the Registered Dietician regarding proper hand washin	a	
	cranocity juicej.				proper use of hair nets, food	y,	
	1				F. Spor acc of rial floto, 1000		

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE COM			ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	a. building 00			COMPLETED	
		155106	B. WIN			07/27/	2012	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIEF	₹			ESTFIELD RD			
DIVEDW	ALK VIII ACE							
RIVERW	ALK VILLAGE			NOBLE	SVILLE, IN 46060			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re I	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	H. 1 tray of 30 s	small cups of liquid stored			storage, food dating and food			
	on the walk-in refrigerator floor without				service are all completed unde			
		use by or preparation			proper sanitary conditions.Diet			
	date. Same as al				manager and/or designee will	do		
	date. Same as at	bove.			daily rounds to ensure kitchen			
					service is completed within pro			
	The following w	as observed in the dry			sanitary conditions in relations with items inserviced.4. How			
	storage area:				the corrective action be monitor			
	_				to ensure the alleged deficient			
	I 2 hoves of har	nanas were located on the			practice does not recur?To			
					ensure ongoing and consisten	t l		
	floor.				compliance, the			
					Dietician and/or Dietary			
	J. 2 boxes of extra wide egg noodles				Manager is responible for			
	were located on	the top storage shelf less			completion both the Sanitation			
	than 12 inches fr	om the ceiling.			Review and			
					the Handwashing CQI audit to			
	The fellowing w	as observed in the			These audits will occur weekly			
	_	as observed in the			4 weeks, then bi-monthly for 2			
	kitchen area:				months and quarterly until compliance is consistently met			
					and maintained for 6 months.			
	K. 1 rolling rack	was observed to have 7			The results of these audits will	he		
	trays of cookies	[in plastic wrap] with			reviewed by the CQI committe			
	individual cups of	of pudding [not covered,			with action plans completed wi			
	_	1 tray of 2 pies [not			failed threshold.			
	_							
	covered, open to	anj.						
		10:25 A.M., in an						
	interview, the D	M indicated he was aware						
	there was a conc	ern with labeling and						
		of food with his dietary						
	staff. He indicat							
	_	aff regarding proper						
	labeling and stor	rage of food.						
	3. On 7/23/1 2 at	t 11:05 A.M., tour of the						
		ated with the Assistant						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155106	A. BUI	A. BUILDING 00 COMPLETED 07/27/2012			
		155106	B. WIN			07/27/	2012
NAME OF F	PROVIDER OR SUPPLIE	3			ADDRESS, CITY, STATE, ZIP CODE		
RIVERW	ALK VILLAGE				SVILLE, IN 46060		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	Director of Nurs	<u> </u>		TAG			DATE
	Director of Nurs	ing [ADON].					
	hospice services #47's room was individual cans of	as identified as receiving At that time, Resident observed with 3 flats of of 2 calorie HN ored on the resident's					
	the ADoN indica provided the sup on the resident's	on 7/23/12 at 11:45 A.M., ated the hospice agency oplement and stored them floor. She indicated she from the floor and place in					
		t 4:30 P.M., observation ion of the evening meal					
	· · · · · · · · · · · · · · · · · · ·	itchen staff were airnets that did not cover					
	and Dietary Aid	45 P.M., Dietary Aide #1 e #2 were observed we in the facility's Moving					
	ace wrap on her was observed se	was observed to have an left hand/wrist area. She tting up the steam table.					
1	Dietary Aide #1	was not observed					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155106	B. WIN	G		07/27/	2012
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					STFIELD RD		
RIVERW	ALK VILLAGE			NOBLES	SVILLE, IN 46060		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ds upon entry into the					
	Moving Forward	l units kitchen area.					
	<u>-</u>	was observed preparing a					
	_	resident without					
	washing her han	ds.					
	Dietary Aide #2 was observed to wash her						
	hands upon entry into the unit kitchen;						
	however, she left the kitchen to get paper						
	towels for the hand washing sink and						
		her hands prior to					
	doming gloves to	o begin serving residents.					
	5 0 5/24/12	. 5.40 D.16 .:					
		t 5:30 P.M., in an					
	-	M indicated he was aware					
	_	lem with handwashing					
		dy discussed the issues					
	I	le #1 and Dietary Aide					
	_	Dietary Aide #1's injured					
	hand, he indicate	ed she was only able to					
	wash the right ha	and and he didn't want to					
	tell her not to wo	ork. He indicated he					
	would discuss he	er injury with					
	management.						
	6. On 7/24/12 at	t 6:00 P.M., in an					
	interview, the Ac	dministrator and DoN					
	indicated all emp	ployees must be able to					
	wash both hands	while working and they					
		e issue with the DM.					
	7. On 7/26/12 at	t 12:30 P.M., the facility					
	Administrator pr	rovided the policy and					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 07/27/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE STFIELD RD SVILLE, IN 46060	017217	2012
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAU	procedures titled Preparation and I and "Food Storag The General Foo Handling policy but was not limit items will be pre maximum nutriti injurious organis Procedure: Food for storage" The Food Storag included, but wa Sufficient storag to keep food safe appetizing stor to prevent contar	Handling," dated 4/11 ge," dated 4/11. d Preparation and and procedure included, ed to, "Policy: Food pared to conserve ve value be free from ms and substances I is covered or wrapped e policy and procedure is not limited to, "Policy: e facilities are provided e, wholesome, and ed by methods designed mination Procedure:		TAU			DATE
	Containers with a be used All con accurately labele must be washed or prior to handli Food is stored a above the floor a sprinkler heads of clean surfaces"	d and dated Hands after unloading supplies ng any food items minimum of 6 inches nd 18 inches below the on clean racks or other					

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	OF CORRECTION IDENTIFICATION NUMBER: 155106	A. BUILDING B. WING	00 	COMPLETED 07/27/2012
	PROVIDER OR SUPPLIER ALK VILLAGE	295	ET ADDRESS, CITY, STATE, ZIP CODE WESTFIELD RD BLESVILLE, IN 46060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	main dining room was observed. One pitcher containing a dark liquid and one pitcher containing a yellow liquid were observed on a small table. Neither pitcher contained a label. During an interview at this same time the Administrator indicated these pitchers contained tea and lemonade for the residents. "Retail Food Establishment Sanitation Requirements Title 410 IAC 724" effective 11/13/04 indicates the following: "SEC 191. (a) Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on one (1) of the temperature and time combinations specified as follows and the day of preparation shall be counted as day one (1):" 3.1-19(f) 3.1-21(i)(2) 3.1-21(i)(3)			

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PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155106	A. BUILDING B. WING	00	COMPLETED 07/27/2012			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
RIVERW	ALK VILLAGE		295 WESTFIELD RD NOBLESVILLE, IN 46060					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	155106	A. BUILDING		07/27/2012
		100100	B. WING		0172172012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
RIVERW	ALK VILLAGE			ESVILLE, IN 46060	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0441	483.65	NTDOL DDEVENT			
SS=E	SPREAD, LINEN	NTROL, PREVENT			
	,	establish and maintain an			
		Program designed to			
environment and to		anitary and comfortable			
	and infection.	d transmission of disease			
	and imedian.				
(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents					
	infections in the	•			
(2) Decides what procedures, such as					
	isolation, should	be applied to an individual			
	resident; and				
	` '	ecord of incidents and s related to infections.			
	corrective action	s related to infections.			
	(b) Preventing S	pread of Infection			
	` '	ection Control Program			
		a resident needs isolation to ad of infection, the facility			
	must isolate the	_			
		ust prohibit employees with a			
		isease or infected skin			
		ct contact with residents or			
	their food, if dire	ct contact will transmit the			
		ust require staff to wash their			
		direct resident contact for			
		hing is indicated by accepted			
	professional prac	ctice.			
	(c) Linens				
		handle, store, process and			
transport linens so as to prevent the spread					
	of infection.				
	Based on intervi	ew and record review, the	F0441	F441 Infection Control / Preve	ent / 08/26/2012
	facility failed to	ensure a tuberculin skin		Spread - it is the consistent	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X2)			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUII	LDING	00	COMPLETED
		155106	B. WIN		•	07/27/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	ę.		295 WE	STFIELD RD	
	ALK VILLAGE				SVILLE, IN 46060	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
		osis [PPDPurified			practice of this Provider to ens a tuberculin skin test for	ure
	Protein Derivativ	U 1			tuberculosis is administered pr	rior
	administered pri	or to, or upon, admission			to or upon admission.1. What	
	for 5 of 6 resider	nts admitted to the facility			Corrective action will be	
	since the last Re	certification survey			accomplished for those reside	
	ending on 6/17/1	1; and failed to			found to have been affected by	
	_	nual tuberculin skin test			the alleged deficient practice? Resident #4 - based on a facili	
		a sample of 24 residents			internal audit, this Provider	ıty
		dents #4, #17, #28, #32,			identified this issue and proper	rlv
	#33, #34, and #2				corrected by providing this	,
	#33, #34, and #2	.01]			resident with a PPD on	
	F. P				6/7/12.Resident #17 - based o	
	Findings include	:			facility internal audit, this Provi	
					identified this issue and proper	rly
	1. The clinical r	ecord for Resident #4			corrected by providing this resident with a PPD on	
	was reviewed on	1 7/23/12 at 2:40 P.M.			6/5/12.Resident #201 - this	
	Diagnoses include	ded, but were not limited			resident was given an PPD on	
	to, history of acu	ite respiratory failure,			4/21/12.Resident #33, #34, #2	
	diabetes, history	of a cerebral vascular			#32 - residents were provided	
		.], and morbid obesity.			with a PPD2. How will this	
		3,			Provider identify other residen being affected by the same	is
	The resident was	s admitted to the facility			alleged deficient practice?All	
	on 4/19/12.	, warring to the taction			residents that are admitted and	d
	011 4/19/12.				reside in this facility have the	
	The facility also	tranja [aamnutar] haalth			potential to be affected by the	
	1	tronic [computer] health			alleged deficient practice.A fac	ality
		the admission 1st. Step			audit was conducted of all residents to ensure PPD has	
		was administered on			been properly provided to each	h
	6/7/12 and read	on 6/9/12.			resident. Any resident without	
					PPD has been given and upda	
	During the daily conference on 7/24/12 at 3:30 P.M., the Director of Nursing was given the opportunity to submit any documentation demonstrating the resident				to be current with this	
					requirement.3. What measure	
					will be put into place and/or whe systematic changes will be ma	
					to ensure that the alleged	luc
		test prior to, or upon,			deficient practice does not rec	ur?
	admission.	1 / 1 /			Nursing staff were re-educated	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		155106				07/27/	2012	
			B. WIN		ADDRESS SITY STATE TIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE			
					ESTFIELD RD			
RIVERW	ALK VILLAGE			NOBLE	ESVILLE, IN 46060			
(X4) ID	SUMMARY			PROVIDER'S PLAN OF CORRECTION	ORRECTION (X5)			
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					on the requirements of providi	ng		
	In an interview	on 7/25/12 at 3:27 P.M.,			residents with a PPD upon			
		Nursing indicated the			admission.A facility audit was			
		n P.P.D. was given late.			conducted of all residents to			
	illitiai/adillissio	II F.F.D. was given late.			ensure PPD has been properl	-		
					provided to each resident. An resident without a PPD has be			
		record for Resident #17			given and updated to be curre			
	was reviewed o	n 7/26/12 at 11:20 A.M.			with this			
	Diagnoses inclu	ided, but were not limited			requirement.Each resident up	on		
	to, Parkinson's	disease, diabetes,			admission will recieve a ppd fr	rom		
	· /	ry of right-side heart			the admitting nurse. The IDT			
	failure, and debility.				team will audit M-F each new			
					admit medical record to ensur			
					PPD properly and timely giver			
		as admitted to the facility			Annual PPD's will be given ba	sed		
	on 3/2/12.				on the admit date and yearly following - the medical records			
					nurse has a calendar/roledex	5		
	The facility elec	ctronic [computer] health			determining when each annua	al		
	<u> </u>	the admission 1st. Step			ppd is due and when to give			
		was administered on			them.4. How will the corrective	re		
	6/5/12 and read				action be monitored to ensure	the		
	0/3/12 and read	011 0/8/12.			alleged deficient practice does			
					not recur?To ensure ongoing			
		y conference on 7/26/12 at			consistent compliance, the DN			
	3:50 P.M., the I	Director of Nursing was			and/or Medical records nurse	IS		
	given the oppor	tunity to submit any			responible for completion the Resident Mantoux CQI au	dit		
	documentation	demonstrating the resident			tool. This audit will occur wee			
		D. test prior to, or upon,			for 4 weeks, then bi-monthly for	-		
	admission.	s. test prior to, or upon,			months and quarterly until	o		
	adinission.				compliance is consistently me	t		
	A	7/27/12 / 2 22 7 3 4			and maintained for 6 months.			
	At the final exit on 7/27/12 at 2:20 P.M., the Director of Nursing indicated she had				The results of these audits wil			
					reviewed by the CQI committee	ee.		
no additional documentation related to a tuberculin skin test prior to, or upon,				If the results of 100% is not				
				achieved, the committee will				
	admission for this resident.				create an action plan to ensur ongoing compliance.	E		
					ongoing compliance.			
	3 The closed o	elinical record for Resident						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
ANDILAN	or condition	155106		LDING		07/27/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF P	PROVIDER OR SUPPLIER				STFIELD RD	
	ALK VILLAGE			l	SVILLE, IN 46060	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
		red on 7/26/12 at 9:20				
		s included, but were not				
	•	tension, diabetes, anemia,				
and aphasia.						
	and aphasia.					
	The resident was	admitted to the facility				
	on 4/20/12.	-				
	The facility elect	tronic [computer] health				
		the admission 1st. Step				
	P.P.D. skin test v	was administered on				
	4/21/12 and read	on 4/23/12.				
	During the daily	conference on 7/26/12 at				
		irector of Nursing was				
	•	unity to submit any				
		emonstrating the resident				
		. test prior to, or upon,				
	admission.	. test prior to, or upon,				
	At the final exit	on 7/27/12 at 2:20 P.M.,				
	the Director of N	Jursing indicated she had				
	no additional dod	cumentation related to a				
	tuberculin skin to	est prior to, or upon,				
	admission for thi	is resident.				
	4 0 7/02/12	1.45 D.M. D. 11. (22)				
		1:45 P.M., Resident 33's				
	record was revie	_				
	,	re not limited to, renal				
	failure, congestiv	· ·				
	behaviors, and de	epression.				
	Resident #33 wa	s admitted to the facility				

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Facility ID: 000044

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	COM	TE SURVEY MPLETED
		155106	B. WING		—	27/2012
	PROVIDER OR SUPPLIEF	2	295 WE	ADDRESS, CITY, STATE, ZIP CO ESTFIELD RD ESVILLE, IN 46060	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	No documentation Resident #33's condmission tuberon 5. On 7/24/12 at #34's record was included, but we	on was located in linical record for an culin skin test. t 2:50 P.M., Resident reviewed. Diagnoses re not limited to, ctures, and left sided				
	Resident #34 was admitted to the facility on 3/7/11.					
	1 -	Orders" dated July 2012, s not limited to, "March skin test]"				
	Resident #34's c	on was located for linical record for an n skin test completed in				
	#28's record was included, but we	t 2:30 P.M., Resident reviewed. Diagnoses re not limited to, frequent and increased weakness.				
	Resident # 28 wa on 6/7/12.	as admitted to the facility				
		on was located in linical record of an				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155106		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2012	
	PROVIDER OR SUPPLIE	R	295 WE	ADDRESS, CITY, STATE, ZIP CODE ESTFIELD RD ESVILLE, IN 46060	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	admission tuber	culin skin test.			
	#32's record was included, but we intellectual disa. Resident #32 was on 12/18/06. A "Physician's Cincluded, but was	Orders" dated July 2012, as not limited to, "April			
	PPD [tuberculin] No documentati	skin test]" on was located in			
		linical record of an n skin test completed in			
	interview with t did not have the testing on the ab indicated nursin facility policy a tuberculin skin to indicated upon to aware there was	t 1:50 P.M., in an he DoN, she indicated she required tuberculin skin love residents. She g staff are aware of the had procedures regarding testing. The DoN facility auditing, she was a concern with residents reculin skin testing r facility policy.			
	provided the fac	t 1:50 P.M., the DoN ility policy and procedure uberculin] Screening.			

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	DF CORRECTION IDENTIFICATION NUMBER: 155106	A. BUILDING B. WING	00	COMPLETED 07/27/2012		
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	The policy and procedure, dated 7/08, included, but was not limited to, "Policy: All residents either prior to or upon admission, in accordance with state and federal regulations will receive a 2-Step Mantoux test for tuberculosis Resident Guidelines: Admission: Administer on day of admission per physician's order if resident has not had a documented negative Mantoux during the preceding 12 months Annual: Administer annually" 3.1-18(e)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. BUILDING 00		COMPLETED			
155106		A. BUILDING B. WING		07/27/2012			
				T ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R					
RIVERWALK VILLAGE			295 WESTFIELD RD				
RIVERW	ALK VILLAGE		NOBL	ESVILLE, IN 46060			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F9999							
	STATE FINDIN	NGS	F9999	F9999 Personal Property - It i	s 08/26/2012		
		105		the consistent practice of this			
	A 1 0 PERGON	A L DD ODED TV		Provider to initiate an inventor	ry of		
	3.1-9 PERSON	AL PROPERTY		personal property of each			
				resident admitted.1. What			
	1. (g) The facil	lity must inventory, upon		Corrective action will be			
	admission and d	lischarge, the personal		accomplished for those reside			
		and valuables declared by		found to have been affected b	, ,		
		ne time of admission. It is		the alleged deficient practice?			
				Resident #17 - a personal			
		sponsibility to maintain		inventory sheet was initated,	lt		
	and update the i	nventory listing of the		completed and updated.Resid	ient		
	resident's person	nal property.		facility2. How will this Provide	nr.		
	1	1 1 3		identify other residents being	;		
	This State Pule	was not met as evidenced		affected by the same alleged			
		was not met as evidenced		deficient practice?All resident	s		
	by:			admitted to this facility have the			
				potential to be affected by the			
	Based on interv	iew and record review, the		alleged deficient practice.An a	l l		
	facility failed to	initiate an inventory of		was completed of current			
		ty for 2 of 6 residents		residents to identify and ensu	re		
	1 1	facility since the last		an inventory sheet has been			
		-		initiated and completed.3. Wh			
		survey ending on 6/17/11;		measures will be put into place	l l		
	^	4 residents reviewed.		and/or what systematic chang	l l		
	[Residents #17 a	and #201]		will be made to ensure that th			
				alleged deficient practice does			
	Findings include	e·		not recur?Admitting nursing s	l l		
	_ mamgs morad			will initiate and fill out an inverse sheet upon admission of each	-		
	1 771 1: : 1	1.C. D. :1		new resident. The Guest	•		
		record for Resident #17		Relations Coordinator will			
		n 7/26/12 at 11:20 A.M.		review M-F each new admit to)		
	Diagnoses inclu	ided, but were not limited		ensure an inventory sheet has			
	to, Parkinson's d	disease, diabetes,		been initated and completed.			
	depression, and			The Guest Relations Coordina	ator		
	Lepression, and	Walletter.		will initiate an inventory of any	<i>'</i>		
		1 10 10 1 0 110		new resident identified as mis	sing		
	The resident wa	s admitted to the facility	1	or incomplete.4. How will the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00		00	COMPLETED		
155106		A. BUILDING B. WING 07/27/2012			07/27/2012		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
DIVEDIMALIA VIII. A OF			295 WESTFIELD RD				
RIVERWALK VILLAGE			NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	on 3/2/12.				corrective action be monitored	to	
					ensure the alleged deficient		
	An inventory she	eet of the resident's			practice does not recur?To		
	l				ensure ongoing and consisten	t	
		y was not located in the			compliance, the DNS and/or		
	hard copy/paper	clinical record.			Medical records nurse is responible for completion of ar	,	
					Inventory Sheet CQI audit tool		
	In an interview of	on 7/26/12 at 1:15 P.M.,			This audit will occur weekly for		
	the Staff Develor	pment Coordinator			weeks, then bi-monthly for 2		
	indicated the facility was still using a paper sheet to document each resident's personal propertythe information was not yet being recorded in the electronic				months and quarterly until		
					compliance is consistently met	t l	
					and maintained. The results o		
					these audits will be reviewed b	-	
					the CQI committee. If the resu	ılts	
	[computer] healt	h records for residents.			of 100% is not achieved, the		
					committee will create an action	1	
	In an interview of	on 7/26/12 at 1:15 P.M.,			plan to ensure ongoing compliance.		
	the Director of N	Jursing indicated the			compliance.		
		_					
	C.N.A.s were required to record personal items on the paper initially following admission, and then have the resident/family/responsible party sign.						
	During the daily conference on 7/26/12 at 3:50 P.M., the Director of Nursing was						
	given the opport	unity to provided any					
		elated to an personal					
		ry upon admission for					
	1 ^ -	ry upon admission for					
	this resident.						
	At the final exit	on 7/27/12 at 2:20 P.M.,					
	the Director of N	Jursing indicated she had					
	no further docum	nentation related to the					
	inventory.						
	in voncory.						
	2 The start 1	inical magand for Desident					
	2. The closed cl	inical record for Resident					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106	(X2) MULTIPLE (A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 27/2012	
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	A.M. Diagnoses	ed on 7/26/12 at 9:20 sincluded, but were not tension, diabetes, eoporosis.					
	The resident was on 4/20/12.	admitted to the facility					
	1	eet of the resident's y was not located in the clinical record.					
	the Staff Develop indicated the fac paper sheet to do personal property not yet being rec	on 7/26/12 at 1:15 P.M., pment Coordinator ility was still using a becument each resident's ythe information was orded in the electronic th records for residents.					
	the Director of N C.N.A.s were rec items on the pape admission, and the	for 7/26/12 at 1:15 P.M., fursing indicated the quired to record personal er initially following then have the esponsible party sign.					
	3:50 P.M., the D given the opported documentation re	conference on 7/26/12 at irector of Nursing was unity to provided any elated to an personal ry upon admission for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155106	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/27/2012
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP 295 WESTFIELD RD NOBLESVILLE, IN 46060	CODE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE COMPLETION
At the final exit on 7/27/12 at 2:20 P.M., the Director of Nursing indicated she had no further documentation related to the inventory.		
3.1-9(g)		

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